Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

Pediatric History Form

Parent 1 First and Last Name*
-

Parent 2 First and Last Name
-

Child's First Name
-

Child's Last Name
-

Age
-

Birthday
-

Birth Height
-

Birth Weight
-

Current Height
-

Current Weight
-

Street Address
-

City
-

State/Province
-

Zip Code
-

Mother's Cell
-

Mother's DOB
-

Father's Cell
-

Father's DOB
-

Purpose of this visit:
-

Child's Current Problem:

What is today's date?
-

What is the childs chief complaint?
-

When did you first notice this?
-

If your child is experiencing Pain/Discomfort please identify where, and for how long:

-

When did this problem begin?

-

Has this problem occurred before?

-

If yes, when?

-

Any bowel or bladder problems since this problem began?

-

If yes, please explain:

-

Have you seen other doctors for this problem?

-

Doctor's Name

-

Approximate date of last visit?

-

Results

-

How is this problem NOW?

-

Please list any medication taken for this problem:

-

Has your child ever sustained an injury playing organized sports?

-

If yes, please explain:

-

Has your child ever sustained an injury in an auto accident?

-

If yes, please explain:

-

Has your child ever suffered from: check applicable items

-

Other:

-

Allergies to:

-

What has been done for the child so far?

-

Is there a history of any problems that I should know about?

-

How was the baby delivered?

-

Was the child breast fed?

-

Was the child vaccinated?

-

Their family history includes which of the following?

-

I understand that I am directly and fully responsible to this office for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request, and authorize imaging studies, and chiropractic adjustments, for the benefit of my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

-

Date

-

Doctor's Signature

-

Date

-